DATE: **DRAFT**

CRITERIA FOR PRIOR AUTHORIZATION

Appropriate NDC Code
(Item or Procedure Here)

Amylinomimetic agents
(Item or Procedure Here)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Pramlintide (Symlin®)

CRITERIA: (must meet all of the following)

1. Patient must be at least 18 years old and have a diagnosis of Type 1 or Type 2 diabetes with HbA1c $\leq$ 9%.

2. Patient must **not** have a diagnosis of gastroparesis or have experienced recurrent severe hypoglycemia in the last 6 months.

3. Documented inadequate glycemic control with current mealtime insulin therapy (HbA1c $\geq$ 7%).

4. Concomitant use of mealtime insulin therapy.

5. Patient must be monitoring blood glucose 3 or more times per day.

Prior Authorizations will be approved for 1 year. Renewals will be approved based on documented improvement to glycemic control (HbA1c), adherence to Pramlintide therapy and blood glucose monitoring, and lack of severe hypoglycemic episodes.

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Drug Utilization Review Committee Director

Date_____

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Pharmacy Program Manager,
Division of Health Policy and Finance

Date_____